

MDR Tracking Number: M5-04-2943-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5-7-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The office visits from 6-4-03 through 9-23-03 **were found** to be medically necessary. The manipulation, joint mobilization, electrical stimulation unattended, hot/cold pack therapy, chiropractic manual treatment and manual therapy technique from 6-4-03 through 9-23-03 **were not** found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 6-29-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- The carrier denied CPT Code 99455-WPL1 on date of service 5-28-03 with a V for unnecessary medical treatment, however, the 99455 is a required disability report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter. Requester submitted relevant information to support delivery of service. The 96 MFG Chapter XXII "Evaluation and Management" ground rules state the treating doctor shall bill using code 99455 with the appropriate modifiers and the reimbursement for specialty areas that shall be rated where referred testing is required is \$50.00. **Recommend reimbursement of \$350.00.**
- The carrier denied CPT Code 99080-73 on date of service 6-4-03 with a V for unnecessary medical treatment based on a peer review, however, the TWCC-73 is a required report and is not subject to an IRO review. The Medical Review Division has jurisdiction in this matter and, therefore, per Rule, recommends reimbursement. Requester submitted relevant information to support delivery of service. Per 134.1(c) **recommend reimbursement of CPT Code 99080-73 in the amount of \$15.00.**

Pursuant to 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003; in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c); plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 5-28-03 through 9-23-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order is hereby issued this 15th day of October 2004.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

NOTICE OF INDEPENDENT REVIEW DECISION

August 5, 2004

AMENDED LETTER 09/09/04

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2943-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 36-year-old male sustained a work related injury on _____. He and an assistant were picking up material for an automatic door frame weighing approximately 80 pounds when his right hand slipped putting the weight onto his left arm, causing pain to his left shoulder. His treatment included; evaluation by a physiatrist, Zanaflex, hydrocodone, Sonata, Vioxx, physical therapy, magnetic resonance imaging (MRI), plain films, cortisone injection, Lidoderm patches, arthroscopy to repair a torn rotator cuff, continuous passive motion (CPM) therapy, hot/cold packs, strengthening exercises, work conditioning, supra-scapular nerve blocks, electro myelogram/nerve conduction study, Zoloft, open revision of a distal clavicle resection, neuroplasty of the suprascapular nerve, Celebrex, amitriptyline, indomethacin, cephalexin, Ultracet, and Theraband.

Requested Service(s)

Manipulation; office visits; joint mobilization; electrical stimulation unattended; hot/cold pack therapy; chiropractic manual treatment; and manual therapy technique for dates of service from 06/04/03 through 09/23/03.

Decision

It is determined that the office visits from 06/04/03 through 09/23/03 were medically necessary to treat this patient's medical condition. However, the manipulation, joint mobilization, electrical stimulation unattended, hot/cold pack therapy, chiropractic manual treatment and manual therapy technique from 06/04/03 through 09/23/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

The records indicated the patient was injured on the job on _____ when he was picking up material for an automatic door frame and his hand slipped, causing pain to his left shoulder. He has received a comprehensive conservative and non-conservative treatment program with minimal benefit.

He was placed at maximum medical improvement (MMI) and given a 26% impairment rating by his treating doctor on 05/28/03. He was seen for a designated doctor's exam on 08/18/03 and placed at MMI on that date with a 20% whole-person impairment rating

National treatment guidelines allow for the treatment this patient received as a result of his on-the-job injury. However, there was no clinical justification or sufficient documentation to warrant ongoing manipulation, joint mobilization, electrical stimulation-unattended, hot/cold pack therapy, chiropractic manual treatment, and manual therapy technique years after the date of injury.

The occasional ongoing office visits were medically necessary to evaluate and case-manage this patient's ongoing problems. Regardless of the final percentage of whole-person impairment, this patient has a significant problem that will require some type of ongoing treatment and case management for an extended period of time.

Therefore, it is determined that it was usual, customary, reasonable, and medically necessary for this patient to receive the office visits from 06/04/03 through 09/23/03. However, the manipulation, joint mobilization, electrical stimulation unattended, hot/cold pack therapy, chiropractic manual treatment, and manual therapy technique provided from 06/04/03 through 09/23/03 were not medically necessary to treat this patient's medical condition.

Sincerely,